American Cancer Society
Cancer Action Network
1 Bowdoin Mill Island, Suite 300
Topsham, ME 04086
207.373.3707
www.acscan.org

To: Members of the MaineCare Redesign Task Force
Fr: Hilary Schneider, Director of Government Relations and Advocacy, American Cancer Society Cancer Action Network (373.3707, email: hilary.schneider@cancer.org)
Date: September 25, 2012
Re: Potential MaineCare Savings Initiatives that Improve Cancer Prevention and Treatment

The American Cancer Society Cancer Action Network (ACS CAN) is nonprofit, nonpartisan advocacy affiliate of the American Cancer Society. ACS CAN supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem.

ACS CAN recommends that the MaineCare Redesign Task Force explore initiatives where there is not only evidence to produce cost savings, but also improve the care received by patients with serious and chronic illnesses, like cancer. Improvements in care management, including ensuring that members are receiving evidence-based care, further implementation of medical homes, and increasing access to palliative care and an enhanced tobacco cessation benefit are all ways in which care can be improved and MaineCare costs lowered/savings achieved.

This memo is intended to provide further information on some of the options outlined above.

Tobacco Cessation Coverage

As you have heard previously from Andy MacLean of the Maine Medical Association, providing evidence-based coverage for tobacco cessation to all MaineCare members is sound health and fiscal policy. Tobacco use remains the single largest preventable cause of disease and premature death in the United States. Moreover, since tobacco use is highest among those with less education and lower incomes, smoking also contributes to greater health disparities. Accordingly, individuals enrolled in Medicaid suffer from smoking-related death and disease in greater numbers than the rest of the population.

Approximately 41% of individuals enrolled in MaineCare smoke. This is compared to a smoking rate of 17% for adults in Maine and 37% for Medicaid enrollees nationally. Moreover, 10.6% of MaineCare expenditures, which is equivalent to $216 million, are attributed to tobacco use. Moreover, children in low-income families or who have a parent that smokes have a higher chance of becoming smokers themselves. Tobacco use increases the risk of at least 15 types of cancer. Thirty percent of all cancer deaths, including 87 percent of lung cancer deaths, can be attributed to using tobacco. Thirty percent of all cancer deaths are due to tobacco use alone. According to the 2008 Maine CDC Behavioral Risk Factor Surveillance System survey (BRFSS), 76% of MaineCare smokers have a desire to quit smoking.

Despite these staggering figures, we know that there are smart investments that can be made to decrease tobacco use and increase population-wide smoking cessation rates. Individuals with insurance coverage for tobacco cessation services are 40% more likely to quit smoking

successfully. When parents quit smoking, smokefree homes mean less asthma and other respiratory disease, less risk of Sudden Infant Death Syndrome (SIDS), and less risk of low-birth weight babies – children's health problems directly linked to smoking in the home.

Moreover, starting in 2013, states can choose to include cessation services (graded "A" by the U.S. Preventive Services Task Force) in Medicaid benefits and receive a 1 percent increase in federal matching funds for these services.

Studies of the Massachusetts Medicaid tobacco cessation benefit found that a positive return on investment happens within one year. A recent study of this benefit by George Washington University found a $2.21 net gain for every $1.00 spent on the Massachusetts Medicaid cessation benefit. According to John Auerbach, Commissioner of the Massachusetts Department of Public Health, after implementation of the Medicaid cessation benefit, smoking prevalence among MassHealth adults decreased to 28% (from 38%), over 33,000 members quit smoking, and successful quit attempts increased significantly from 6.6% to 18.9%. In addition, health impacts were observed within one year, including a 46% decrease in probability of hospitalization for heart attack and 49% decrease in probability of hospitalization for acute coronary heart disease.

The tobacco cessation benefit in MaineCare should be heavily promoted to members and improved (by covering tobacco cessation medications and reducing remaining barriers to utilizing the benefit). This could result not only in improved health outcomes for MaineCare members, but also short- and long-term cost savings.

Palliative Care Programs

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with the patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

A growing number of studies have found that broader implementation and use of interdisciplinary palliative care programs provide a way to improve quality and reduce cost for some of the most seriously ill Medicaid patients. A study published in *Health Affairs* in March 2011 examined the effect on hospital costs of palliative care for Medicaid patients at four New York State hospitals. The study found that, on average, patients who received palliative care incurred $6,900 less in hospital costs during a given admission than a matched group of patients who received usual care.

The study's authors estimated that New York could eventually see reductions in Medicaid hospital spending of $84 million to $252 million annually through the use of palliative care consultation teams in every hospital with 150 or more beds. The main savings come from shortening hospital stays and keeping patients out of the Intensive Care Units. The researchers also stated that targeted access to palliative care could lead to savings for state Medicaid programs beyond the hospital costs evaluated in the study and could reduce pressures to cut other

important Medicaid services. They went on to say that "the contribution of palliative care teams are key to reducing readmissions, emergency department visits, and unnecessary inpatient and outpatient services, and they need further evaluation." The full study can be found at: http://content.healthaffairs.org/content/30/3/454.full.pdf+html.

It is important to note that other studies have found that advanced cancer patients who received early palliative care in combination with standard care not only reported increased quality of life, but also lived longer than those who did not receive palliative care.

Thank you for the opportunity to provide this information on potential savings initiatives. Please let me know if you have questions or need further information.

Contributions or gifts to the American Cancer Society Cancer Action Network, Inc. are not tax-deductible because we use your donations to support our citizen-based advocacy and lobbying efforts to end cancer.

Cancer Action Network
American Cancer Society

10th Edition

HOW DO YOU **MEASURE UP?**

A Progress Report on State Legislative Activity to Reduce Cancer Incidence and Mortality

AUGUST 2012

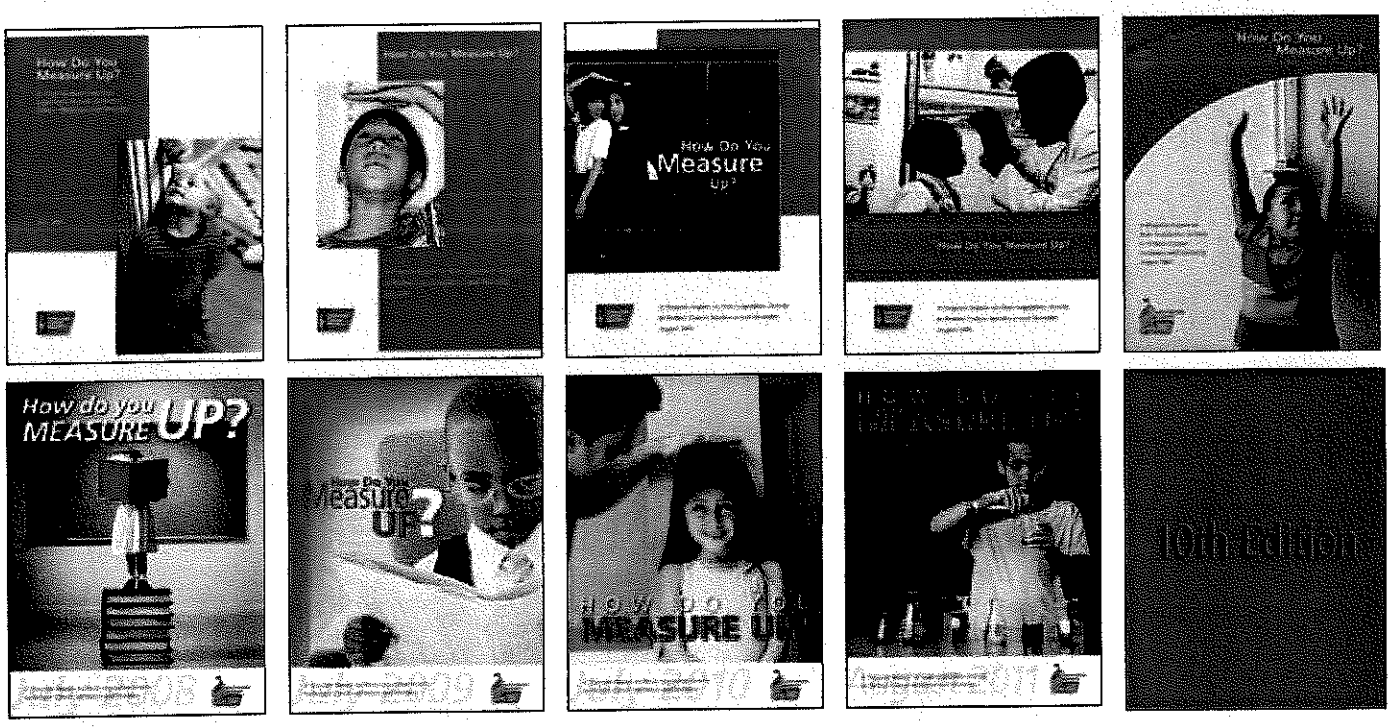
Mission Statement

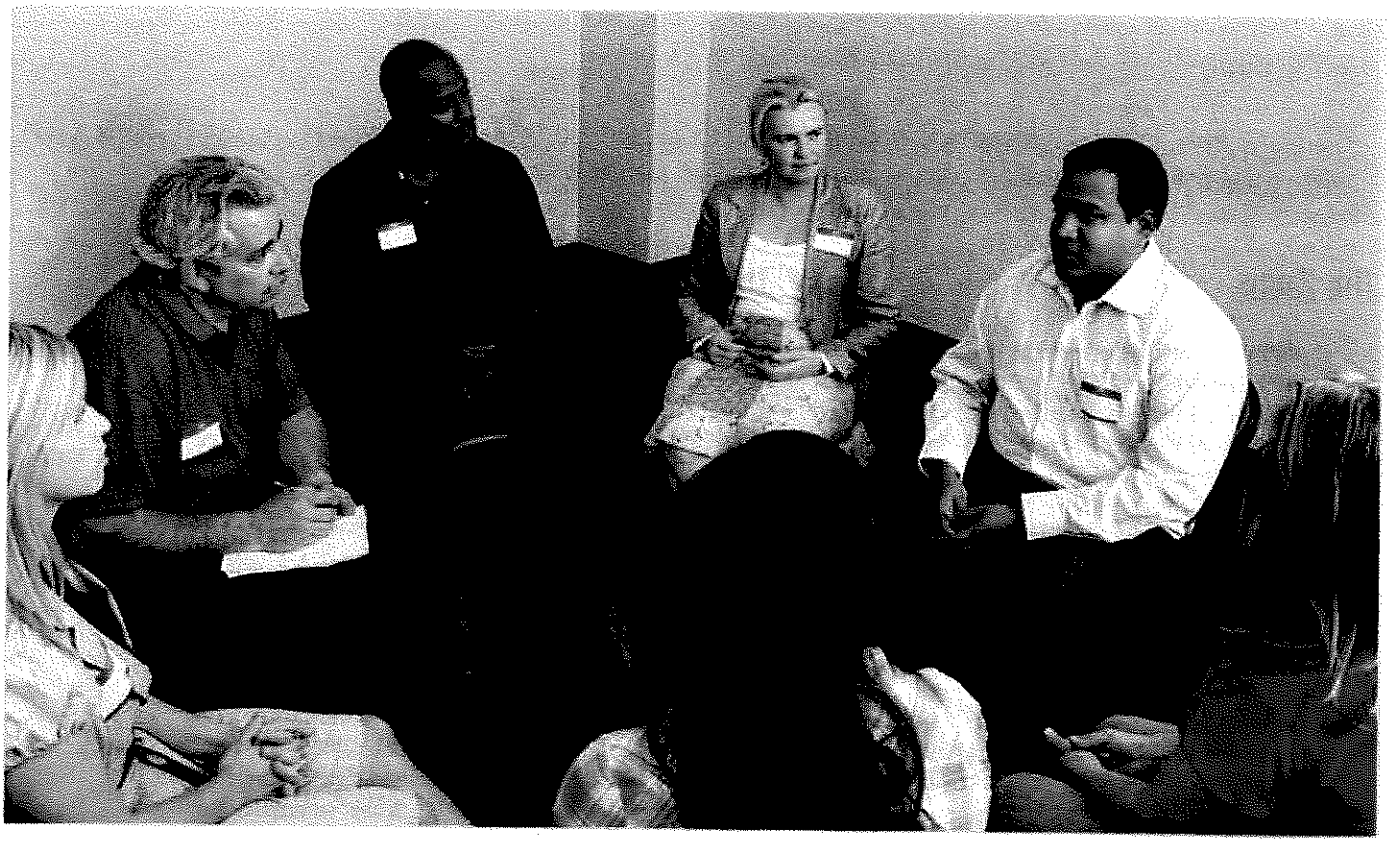
American Cancer Society Cancer Action Network (ACS CAN)

The American Cancer Society Cancer Action Network (ACS CAN) is the nation's leading voice advocating for public policies that are helping to defeat cancer. As the advocacy affiliate of the American Cancer Society, ACS CAN works to encourage elected officials and candidates to make cancer a top national priority. ACS CAN utilizes its expert capacity in lobbying, policy, grassroots and communications to amplify the voices of patients in support of laws and policies that save lives from cancer. For more information, visit www.acscan.org.

Our Tenth Edition

This tenth edition of *How Do You Measure Up?* illustrates how states stand on issues that play a critical role in reducing cancer incidence and death. The goal of every state should be to achieve "green" in each policy area delineated in the report. By implementing the solutions set forth in this report, state legislators have a unique opportunity to take a stand and fight back against cancer. In many cases, it costs the state little or nothing to do the right thing. In most cases, these solutions will save the state millions and perhaps billions of dollars in health care costs and increased worker productivity. If you want to learn more about ACS CAN's programs and/or inquire about a topic not covered in this report, please contact the ACS CAN state and local campaigns team at (202) 585-3206 or call our toll-free number, 1-888-NOW-I-CAN, 24-hours a day, seven days a week. You can also visit us online at www.acscan.org.





The Challenge

Public health experts have long supported proven strategies to prevent children and adults from smoking and to get smokers to quit. States with comprehensive tobacco control programs that include cessation services for a wide scope of their population experience faster declines in cigarette sales, smoking prevalence and lung cancer incidence and mortality than states that do not invest in these programs.

Only six states (Indiana, Massachusetts, Minnesota, Nevada, North Carolina and Pennsylvania) provide comprehensive cessation coverage for all Medicaid beneficiaries. Only nine states require private insurance plans to cover tobacco cessation treatments. While the Affordable Care Act (ACA) requires non-grandfathered private health plans to offer cessation coverage, at this time there are no guidelines or requirements for effective and comprehensive cessation coverage. Only five states offer comprehensive cessation coverage for their own employees.

State investment in telephone cessation counseling is far below what the CDC recommends as adequate funding for this valuable, proven resource. Only four states (Maine, North Dakota, South Dakota and Wyoming) fund telephone-based tobacco cessation services (quitlines) at the recommended levels.

Evidence shows that administrative barriers like co-pays, pre-authorization requirements and administrative "red tape" can deter people from utilizing preventive services such as cessation treatment. In 25 state Medicaid programs, co-pays are required for every cessation-related prescription filled or every cessation counseling visit. Twenty-three states restrict the number of quit attempts covered in a year and, in least 23 states, Medicaid programs limit the number of weeks the tobacco treatment programs are covered or the number of covered quit attempts per year. Nine states do cover all evidence-based cessation medications, but not counseling.

Affordable Care Act Cessation Provisions:

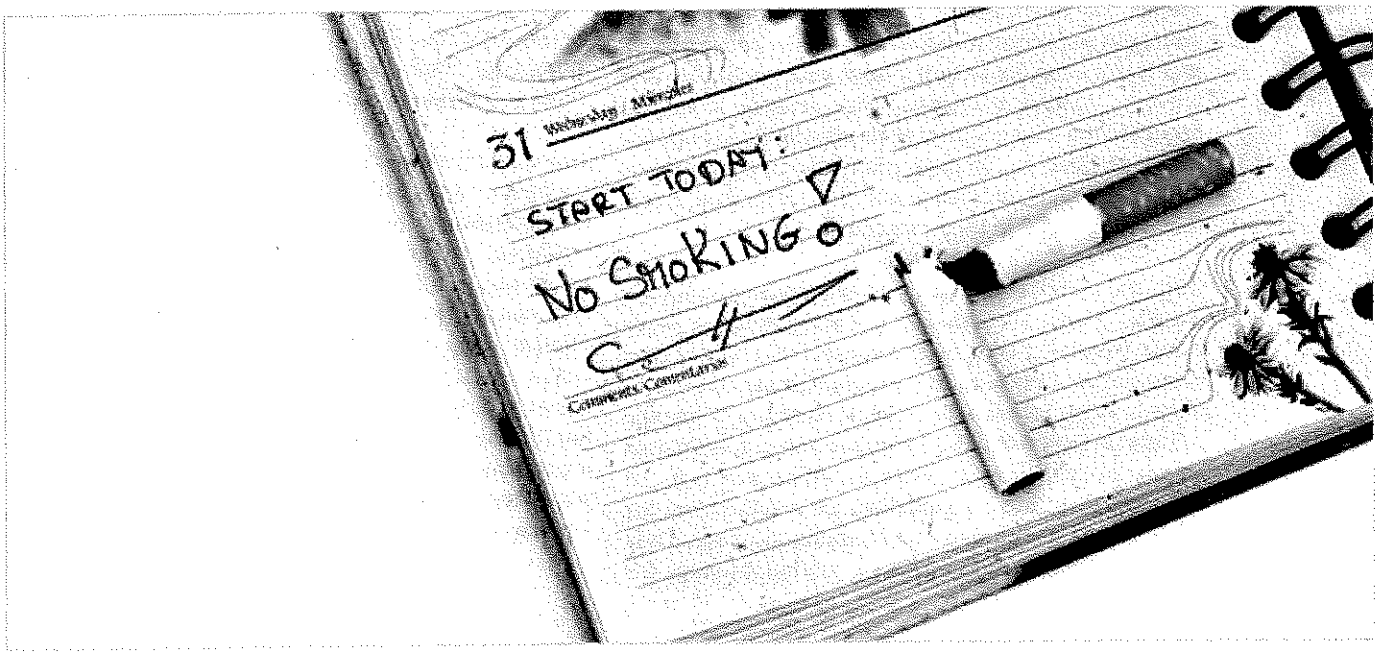
Starting in 2013, states can choose to include cessation services (graded "A" by the U.S. Preventive Services Task Force) in Medicaid benefits and receive a 1 percent increase in federal matching funds for these services.

The Facts

- Almost 70 percent of current smokers want to quit completely.[1]
- 52 percent of smokers make a quit attempt each year, but only about 6 percent of smokers will actually stop smoking.[2]
- Less than a third of smokers trying to quit will use evidence-based treatments to help. Including evidence-based cessation services as a covered health benefit increases quit rates by 30 percent.[3]
- Providing both medication and professional counseling in cessation treatments increases quit rates by 40 percent.[4]
- Smokers and other tobacco users need access to a range of treatments and combinations of treatments to find the most effective cessation tools that work for them.
- Quitlines can increase quit success more than 50 percent, compared to using no cessation intervention.[5]

The Solution

Implementing cessation benefits to all state employees, Medicaid beneficiaries and other smokers, and having these benefits cover a range of treatment options, will curb states' tobacco-related death and disease and save money. Covering all population groups through insurance plans is critical, especially for low-income populations that need it most. Throughout the implementation phase of the ACA, ACS CAN will be working to ensure that a full range of cessation services are covered at all levels of benefits and in all plans. State and local governments should also take advantage of Centers for Disease Control and Prevention Community Transformation Grants, which support community-level efforts to reduce chronic diseases such as heart disease, cancer, stroke and diabetes, as well as other funding opportunities to significantly increase resources for state-sponsored quitlines.



Updated 2/22/2012

Massachusetts Commonwealth Care Health Plans
Tobacco Cessation Benefit Coverage
Return on Investment (ROI) Calculation

The ROI (return on investment) model estimates health care savings if all Commonwealth Care health plans adopted a tobacco cessation benefit that is similar to MassHealth: free or low co-pay tobacco medications and counseling. The model estimates the number of people who quit smoking, the cost of tobacco treatment, medical savings from reduced hospitalizations for heart attacks and coronary artherosclerosis, and the return on investment.

- **The additional number of people who quit smoking each year is 270.**
- **The 5-year net savings is $2,071,927.**

5-Year Return on Investment Summary

	Year 1	Year 2	Year 3	Year 4	Year 5	Total
Estimated Cost	$ 184,083	$ 189,606	$ 195,294	$ 201,153	$ 207,188	$ 977,324
Medical Savings	$ 574,340	$ 591,571	$ 609,318	$ 627,597	$ 646,425	$ 3,049,252
[1] Return on Investment	$ 390,257	$ 401,965	$ 414,024	$ 426,444	$ 439,238	**$ 2,071,927**

[2] Rating of Tobacco Treatment Coverage

Health plan	*Rating Summary*
Type I plans	Low co-pay, counseling available
Type II and III plans	High co-pay, counseling benefit is uneven

Figures Used in ROI Calculation

[3] **# of Commonwealth Care Members (Age 18+)**	**Total**
Total - Type II and Type III	77,607
[4] % of current adult smokers	18%
Number of adult smokers	13,969
Annual Medication Benefit Use (additional use above current levels)	
[5] % of members using medication (annual)	8.8%
# of members using medication (annual)	1,229
[6] Cost per member user	$140
Total annual medication cost	$172,098
Annual In-Person Counseling Benefit (additional use above current levels)	
[5] % of members using counseling	1.1%
# of members using counseling	154
[6] Cost per member using counseling	$78
Total annual counseling cost	$11,985
[7] **Annual number of people who quit**	**270**

Massachusetts Department of Public Health
Tobacco Control Program
(617) 624-5900 www.mass.gov/dph/mtcp

Make smoking history.

Notes

[1] Estimated ROI of $2.12 for each $1 spent based on the following published study on the MassHealth program.
Richard P, West K, Ku L (2012) The Return on Investment of a Medicaid Tobacco Cessation Program in Massachusetts.
PLoS ONE 7(1):e29665.doi:10.1371/journal.pone.0029665

[2] The rating is based on a comparison with MassHealth insurance coverage: all FDA tobacco treatment medications are covered with a $1 to $3 co-pay. A "high" co-pay is above this level.

[3] The number of Type II and Type III members is from March 2010 data from Cognos, the enterprise reporting system for Masshealth and Commonwealth Care. Accessed online at https://gateway.hhs.state.ma.us/authn/login.do.

[4] The 18% smoking rate is based on BRFSS 2008-2010 for those who selected Commonwealth Care as their insurance plan.

[5] Based on 2010 MA BRFSS data, MassHealth smokers used tobacco cessation medications at a rate 8.8% higher than smokers with private health insurance. As a result, we estimate that no or low-copay medications would increase annual utilization by 8.8%.
A counseling+C35 benefit with no or low co-pay would increase counseling utilization by 1.1% based on MassHealth data.

[6] Based on MassHealth, Office of Clinical Affairs data from FY 2009, cost per user for medications was $140 and $78 for counseling. Assumes an inflation factor 3% per year after year 1.

[7] Based on the Massachusetts Smokers' Helpline, the 30-day quit rate at 7-month follow-up is 19.5% (April 2010 to September 2011).

Palliative Care:
A Solution to Our Fragmented and Costly Health Care System for Patients with Chronic Illness

What is palliative care?

It is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness – whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with the patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.

Peer reviewed scientific studies reveal that patients with chronic illness who receive palliative care have reduced symptoms. They have better quality of life, less pain, less shortness of breath, less depression, and less nausea.

In addition, their families are more satisfied. The provision of palliative care can lead to a more efficient health care system by decreasing costs without reducing services, and by creating new innovations in treatment.

Landmark scientific studies prove the value of palliative care

A 2010 clinical study of 151 lung cancer patients showed that early palliative care provided alongside cancer treatment delivered better patient quality of life and longer patient survival time.[1]

A second 2011 study revealed that hospital palliative care teams created efficiencies that delivered significant health cost savings. Patients enrolled in Medicaid at four New York state hospitals benefitting from integrated palliative care team consultations incurred $6,900 less in hospital costs during a given admission. They spent less time in intensive care and were less likely to die in intensive care units. This translated to estimated reductions in Medicaid hospital spending in New York ranging from $84 million to $252 million annually if every hospital with 150 or more beds had a fully operational palliative care consultation team.[2]

An earlier 2008 study of eight diverse hospitals showed that palliative care consultations resulted in adjusted net savings of $1,696 in direct costs per admission and $279 in direct costs per day, including significant reductions in laboratory and intensive care unit costs.[3]

1. Temel JS, Greer JA, Muzikansky A, Gallaher ER, Admane S, Jackson VA, Dahlin CM, Blinderman CD, Jacobsen J, Pirl WF, Billings JA, Lynch TJ. Early palliative care for patients with metastatic non-small cell lung cancer. *NEJM* 363(8)733-742 (2010).

2. Morrison RS, Dietrich J, Ladwig S, Quill T, Sacco J, Tangeman T, Meier DE. Palliative care consultation teams cut hospital costs for Medicaid beneficiaries. *Health Affairs* 30(3)454-463 (2011).

3. Morrison RS, Penrod JD, Cassel JB, Caust-Ellenborgen M, Litke A, Spragens L, Meier DE. Cost savings associated with US hospital palliative care consultation programs. *Arch Intern Med* 168(16)1783-1790 (2008).

Cancer Action Network℠
American Cancer Society®